Provider Order Form

AMVUTTRA (VUTRISIRAN)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date:

DIAGNOSIS ICD-10 code (must be specified)

☐ Neuropathic heredofamilial amyloidosis E85.1 ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ AMVUTTRA (vutrisiran), Subcutaneous Injection	☒ 25 mg	☒ 25 mg administered by subcutaneously once every 3 months.

Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance Card ☐ Progress Notes Supporting DX ☐ Tests supporting primary diagnosis

Provider Signature Date